84 2

No. 07-969

FILED
FEB 25 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

V.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.,
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

BRIEF IN OPPOSITION

Robert L. Harris, Jr., Esquire
LECLAIRRYAN, A Professional Corporation
Riverfront Plaza, East Tower, 8th Floor
951 East Byrd Street
Post Office Box 2499
Richmond, Virginia 23218-2499
Telephone: (804) 783-2003
Facsimile: (804) 916-7666

Counsel for the Respondents

LANTAGNE LEGAL PRINTING
801 East Main Street Suite 100 Richmond, Virginia 23219 (800) 847-0477

RESTATEMENT OF QUESTIONS PRESENTED

I. AS A THRESHOLD ISSUE, DOES THE COURT OR THE JURY DECIDE WHETHER A PROFESSIONAL REVIEW ACTION SATISFIES THE STANDARDS OF THE HEALTH CARE QUALITY IMPROVEMENT ACT?

II. DID THE TRIAL COURT APPLY AN OBJECTIVE REASONABLENESS STANDARD WHEN EVALUATING WHETHER THE PEER REVIEW ACTION WAS REASONABLE?

III. DID THE TRIAL COURT PROPERLY CONCLUDE THAT DR. MEYERS' ACTIONS WERE UNREASONABLE AND, THEREFORE, DID IT PROPERLY EXERCISE ITS DISCRETION WHEN AWARDING RIVERSIDE A PORTION OF ITS ATTORNEY'S FEES?

PARTIES TO THE PROCEEDING

All of the individual respondents are named in the caption of the case. For ease of reference, respondent Riverside Hospital, Inc., and the individual respondents shall be referred to as "Riverside."

TABLE OF CONTENTS

Table of Authorities iii

Opinions Below 1

Statement of the Case 3

Reasons for Denying the Petition 19

Conclusion 45

APPENDIX

A. January 13, 1999, Letter of Dr. Jay M. Cooper, M.D. to Dr. Freeman

B. Riverside Regional Medical Center Panel Hearing, May 23, 2001

C. *Brandi M. Penny v. Paul J. Meyers, M.D.*, Motion for Judgment, Newport News Circuit Court

D. September 25, 2000, Letter of John R. Partridge, M.D. to Thomas T. Thames, II, M.D.

E. December 26, 2000, Report of Jordan C. Pritzker, M.D.

F. Investigative Committee Report, July 15, 2000

G. June 8, 2001, Letter of William B. Downey to Paul Meyers, M.D.

H. Affidavit of Paul J. Meyers, M.D., December19, 2007

TABLE OF AUTHORITIES

STATUTES AND AUTHORITIES

Health Care Quality Improvement Act,
42 U.S.C. § 11101 *et seq.* 1

42 U.S.C. § 11111(a)(1) 40, 41

42 U.S.C. § 11111(a)(2) 41

42 U.S.C. § 11112(a)(3) 27

42 U.S.C. § 11112(c)(2) 9

42 U.S.C. § 11113 33

Sup. Ct. R.
Rule 15(2) 3

Sup. Ct. R.
Rule 50(b) 25

CASES

Addis v. Holy Cross Health Care Sys. Corp.,
88 F.3d 482 (7th Cir. 1996) 33, 34

Austin v. McNamara, 20, 21,
979 F.2d 728 (9th Cir. 1992) 23, 44

Brader v. Allegheny Gen. Hosp.,
167 F. 3d 832 (3d Cir. 1999) 20

Brown v. Family Pract. Asoc.,
101 F.3d 1324 (10th Cir. 1996) 21

Bryan v. James E. Holmes Reg. Med. Ctr.,
33 F.3d 1318 (11th Cir. 1994) 21, 23, 24, 25, 26, 29

California v. Federal Energy Reg. Comm'n,
495 U.S. 490 (1990) 41

Freilich v. Upper Chesapeake Health, Inc.,
313 F.3d 205 (4th Cir. 2002) 42

Gabaldini v. Washington Cty. Hosp.,
250 F.3d 255 (4th Cir. 2001) 20

Imperial v. Suburban Hosp. Ass'n,
37 F.3d 1026 (4th Cir. 1994) 44

Johnson v. Nyack Hosp.,
964 F.2d 116 (2d Cir. 1992) 34

Khoury v. Community Mem. Hosp.,
203 Va. 236 S.E.2d 533 (1962) 32

Medical Ctr. Hosp. v. Terzis,
235 Va. 443, 367 S.E.2d 728 (1988) 32

Meyers v. Columbia/HCA Healthcare Care,
341F.3d 461 (6th Cir. 2003) 20

Muzquiz v. W.A. Foote Mem. Hosp.,
70 F.3d 422 (6th Cir. 1995) 34

Patel v. Midland Mem. Hosp.,
298 F.3d 333 (5th Cir. 2002) 43

Singh v. Blue Cross/Blue Shield of Mass., Inc., 20,23, 24,26,
308 F.3d 25 (1st Cir. 2002) 43

Smith v. Ricks,
31 F.3d 1478 (9th Cir. 1994) 34

Sugarbaker v. SSM Health Care, 20, 34,
190 F.3d 905 (8th Cir. 1999) 43

OPINION BELOW

Riverside substantially concurs with Dr. Meyers' recitation of the trial court's letter opinions and orders in his Appendix to the *Petition for Writ of Certiorari.* The only material misstatements relate to (1) the trial court's ruling on Riverside's initial *Demurrer*[1] to Dr. Meyers' action and (2) when Riverside first pleaded the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11101 *et seq.,* as an affirmative defense.

Contrary to Dr. Meyers' suggestion, the trial court did not sustain any general *Demurrer* to his count for defamation. In fact, Riverside did not demur entirely to that count. A previous co-

---

[1] A demurrer is akin to a 12(b)(6) motion: has the plaintiff stated a cause of action upon which relief can be granted?

defendant, which is not a party to this appeal, demurred to that count, and Riverside, as a corporate defendant, demurred only to the extent that Dr. Meyers sought punitive damages against the hospital for allegedly defamatory statements that Dr. Meyers did not contend that Riverside had ratified. The trial court sustained the demurrer on those bases alone and not to the count for defamation in its entirety.

Moreover, Riverside did not wait until Dr. Meyers filed his *Third Amended Motion for Judgment* to plead HCQIA as an affirmative defense. In fact, Riverside invoked that defense upon Dr. Meyers' filing of his *Second Amended Motion for Judgment* two years earlier. Riverside's reason for delay is clear from the record below: in previous filings Dr. Meyers had not pleaded enough facts,

ironically, to demonstrate on the face of the pleadings that Riverside's peer review action was reasonable. In effect, as Dr. Meyers' description of the peer review process mushroomed in each amendment, he disclosed more of the due process afforded to him. In effect, Dr. Meyers pleaded away his case.

STATEMENT OF THE CASE

This Court expects counsel to disclose in a brief in opposition all perceived misstatements of facts or law. *See* Sup. Ct. R. 15(2). The trial court disposed of this case by deciding as a matter of law that Dr. Meyers' allegations fail to state a cause of action. Before ruling, the trial court considered the allegations and documents in the *Third Amended Motion for Judgment,* as amplified by Dr. Meyers' *Motion for Reconsideration,* as well as additional

documents that Riverside placed in the record that Dr. Meyers had described but not included in his pleadings. Although Dr. Meyers does not openly challenge the trial court's finding that Riverside's peer review action was reasonable, he does inject allegations designed to taint this Court's perception of Riverside. Any thoughtful review of the trial court's basis for ruling requires a more complete presentation of the facts.[2]

---

[2] In fact, many more admissions by Dr. Meyers should have been before the trial court even before consideration of Riverside's third *Demurrer*. Over a year before trial court dismissed the case based on the insufficiency of Dr. Meyers' allegations, Riverside moved for summary judgment based not only on the allegations in the *Second Amended Motion for Summary Judgment* but also on Dr. Meyers' answers to requests for admissions. The trial court, however, granted Dr. Meyers leave to file a *Third Amended Motion for Judgment* instead of requiring him to respond to Riverside's *Motion for Summary Judgment*.

Riverside's concern about Dr. Meyers' surgical practice did not begin on March 1, 2000, when it summarily suspended him for causing five injuries during surgery in less than four months. His suspension on that date was the second in sixteen months and arose only four months after he had completed a remedial proctorship.

The first suspension arose from a patient's having a heart attack during surgery while Dr. Meyers removed uterine fibroids. During that procedure Dr. Meyers used fluids to distend, or expand, the patient's uterus. If a patient absorbs excessive volumes of distension fluid into her bloodstream, she may have seizures, experience brain damage or even die from cardiac arrest. Consequently, proper monitoring of fluid intake and

output is essential. This patient had a heart attack during surgery.

Dr. Meyers aborted the procedure and administered CPR; the patient survived. Then and now Dr. Meyers deflected blame for her complication: a "lack of fluid balance protocols and forms on which to record fluid balance, lack of [a] closed-circuit system to measure fluid balance accurately, and lack of equipment to measure electrolytes on the premises" caused the patient to suffer a heart attack. *Petition* at 33 (n.14). Although Dr. Meyers is quick to point out that Riverside's external reviewer of the patient's chart made these observations, Dr. Meyers fails to disclose that reviewer's observations *directed at him.*

Specifically, the reviewer remarked that at the time of the heart attack, Dr. Meyers and the

attending nurses could not account for approximately 5000cc's of distension fluid, which volume is over three times the limit that should trigger an immediate termination of the surgery. *See* App. A-1, -2.[3] Noting Dr. Meyers' concern over a fluid deficit forty minutes into the procedure, the external reviewer also observed that Dr. Meyers continued the surgery another eighty minutes despite his not having received the results of two tests to determine the extent of absorption of the distension fluid into the patient's bloodstream. "Under no circumstances should an operative hysteroscopic resection of a uterine fibroid extend beyond an hour and 30 minutes." *Id.* A-2. This patient's procedure stopped abruptly after two

---

[3] Dr. Meyers belatedly introduced this report in his *Motion for Reconsideration.*

hours—and only after she went into cardiac arrest. The external reviewer declared,

> The physician was either unconcerned or ignored the potential complication . . . . A lack of clinical judgment was evident in continuing the surgical procedure 50 minutes after asking for an electrolyte determination, administering Lasix and, apparently, being informed by the circulating nurse that the fluid deficit was increasing. . . . [S]eizures, permanent brain damage and death can occur.

Id. Dr. Meyers conveniently ignores these criticisms. In doing so, he also ignores his own admission of responsibility at an internal hearing convened to address his clinical judgment. Asked whether he exhibited "impaired intraoperative clinical judgment" during this patient's surgery, Dr. Meyers conceded, "I think I miscalculated, and I think that—and I think I made a mistake. I think we

all have. Everybody has 10 or 15 minutes in their lives that they'd rather relive." App. B-1.[4]

Dr. Meyers had completed his first proctorship as of March 1, 2000. On that date, however, Riverside's Director of Surgical Services reported the fifth of five injuries sustained by Dr. Meyers' patients within only a three-month period after conclusion of the first proctorship. Those facts prompted Riverside, in full compliance with its Bylaws, to suspend Dr. Meyers' privileges summarily so that Riverside could investigate the cause of the complications. Given the information at hand, Riverside believed that "the failure [to summarily suspend Dr. Meyers] may result in an

---

[4] Dr. Meyers avoided this admission in multiple amendments to his original Motion for Judgment. Nonetheless, in responses to requests for admissions, he admitted previously making this concession

imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2).

Emphasizing that none of the patients suffered "mortality or permanent injury," *Petition* at 8, again Dr. Meyers fails to disclose all of the material facts. Dr. Meyers perforated the rectum of one of the five patients, who was being treated for endometriosis, but he failed to notice the complication until two days after surgery, at which time she underwent a colostomy to correct the injury. That patient filed a civil action against Riverside and Dr. Meyers almost two years later—well after Riverside restored Dr. Meyers' privileges subject to a second proctorship. *See* App. C-1 through C-3.[5]

---

[5] Virginia permits its courts to take judicial notice of court records. The parties settled all claims, the terms of which are confidential.

Riverside's Medical Executive Committee ("MEC") appointed an investigative subcommittee to examine the most recent surgical complications. Contrary to Dr. Meyers' assertion that the subcommittee "relied exclusively on the report of an external reviewer," *Petition* at 9, it actually reviewed peer review actions involving Dr. Meyers in 1995, 1996 and 1999, interviewed Dr. Meyers, and considered the reports of Riverside's outside reviewer and a consultant hired by Dr. Meyers.

Examining each patient's chart, Riverside's external reviewer both praised and criticized Dr. Meyers on a case-by-case basis. Although the reviewer acknowledged in one case that "there were good indications for surgery," *id.* (App. M, 45a), he did not, as Dr. Meyers claims, "withdraw almost all his criticisms." *Id.* at 9. In fact, two other outside

consultants, one of whom Riverside retained after the conclusions of the first reviewer were questioned and the other of whom was retained by another hospital where Dr. Meyers had privileges, reviewed the same records and came to similar conclusions. "[T]he pattern as a whole raises serious concerns. . . . What comes through as a strong impression is that of a surgeon pushing the envelope . . . accumulating complications in the process." App. D-1.[6]

> The charts . . . reflect significant adverse (and costly) outcomes to the care of a number of patients in a short period of time (three months). Many of the outcomes may have been averted by a more judicious selection of the surgeries for the patients or less aggressive intervention in the operating room. These outcomes . . . suggest significant concerns in the management of the

---

[6] Dr. Meyers introduced this reviewer's report as Exhibit 65 to his Brief Opposing Defendants' Craving Oyer.

> patients reviewed and for other potential surgical patients of [Dr. Meyers].

App. E-1.[7]

Among other conclusions, the investigative subcommittee declared,

> [Dr. Meyers'] clinical behavior of aggressive case selection and intra-operative decision-making leads him to proceed when others may take a more conservative approach. This has led to intra-operative misadventures and potentially avoidable complications.
>
> Because of a pattern of this behavior, several prior reviews before the [MEC], and the present action, the committee believes this behavior will not change and will ultimately place patients at an unacceptably high risk.

App. F-1.[8] The investigative committee added that it could not recommend another proctorship because it

---

[7] Riverside introduced this report in its Motion Craving Oyer after Dr. Meyers described the report but did not

believed the previous proctorship had not changed Dr. Meyers' practice. *Id.* F-2. The committee made no recommendation to the MEC with respect to the disposition of Dr. Meyers' privileges.

The MEC convened to deliberate over a recommendation to Riverside's Board of Directors. At the meeting, the chairperson of the OB-GYN Department at Riverside, Karen Bruder, M.D., volunteered that if Dr. Meyers were to perform a laparoscopy on her, she would want to be awake so that she could tell Dr. Meyers when to stop the procedure. Although Dr. Bruder explained almost a year later that the MEC misinterpreted her comment, she never has denied the declaration,

---

attach it as an exhibit to his *Third Amended Motion for Judgment.*

[8] Dr. Meyers introduced the investigative committee's report into the record as Exhibit 66 to his Brief Opposing Defendants' Motion Craving Oyer.

which is consistent with others' observations that Dr. Meyers' "pushes the envelope" and fails to make "judicious selection" of surgeries.

As Riverside's Bylaws allow, Dr. Meyers pursued several appeals. First he appealed the MEC's recommendation and was afforded a hearing before a hearing officer and a panel of five physicians. The hearing panel made several significant findings, most of which Dr. Meyers fails to disclose:

- the MEC and its investigative committee "acted reasonably and in good faith in the handling of the investigation and revocation of clinical privileges of Dr. Meyers."
- Dr. Meyers should have terminated the surgery leading to his first proctorship when he became aware that he could not measure fluid balances.

- Dr. Meyers fails to dictate operative reports promptly after surgery.

The hearing panel recommended that Dr. Meyers' privileges be restored subject to a second proctorship.

Contrary to Dr. Meyers' claim that the MEC still insisted that Dr. Meyers' "clinical judgment was impaired," *Petition* at 11, the MEC actually voted to *reverse* [its] original recommendation for revocation" and made no finding at that time that Dr. Meyers' judgment was impaired. *See* App. G-1 (emphasis added).[9] Unwilling to undergo a second proctorship, Dr. Meyers appealed to Riverside's Board of Directors the MEC's recommendation of another proctorship.

---

[9] See supra n.1. In answers to requests for admission, Dr. Meyers admitted receipt of the MEC's post-hearing recommendation, which is attached as Appendix E.

Riverside's Board of Visitors appointed an Appeals Panel to examine two issues identified by Dr. Meyers: (1) whether the MEC acted reasonably and in good faith; and (2) whether Dr. Meyers should be subjected to a second proctorship. The Appeals Panel concluded, "[T]he history of the matters involving Dr. Meyers were such that the investigating committees found, as they should have, that Dr. Meyers' judgment was questionable." That panel concurred that a proctorship was proper, as a result of which Dr. Meyers was informed of the terms of a second proctorship.

At the end of the process, after Dr. Meyers had completed a proctorship and injured five patients over the next three months, Riverside still restored his privileges subject to a proctorship.

At one time Dr. Meyers declared that he had "nothing to fear from any proctorship." *Third Amended Motion for Judgment* ¶ 155. Several years after Riverside set the terms of proctorship, Dr. Meyers contended that Riverside imposed stringent proctorship conditions. *Id.* ¶ 258. Last year—six years since Riverside imposed the second proctorship—Dr. Meyers conjured a new excuse for failing to complete the proctorship: "it would be unethical for me to inflict on patients an abdominal incision just so I could complete proctorship of my abdominal cases." *See* App. H-1.[10] After his re-instatement at Riverside subject to a proctorship, Dr. Meyers never completed the proctorship.

---

[10] This assertion entered the record after the Virginia Supreme Court denied Dr. Meyers' *Petition for Appeal*.

At the end of six years of litigation, Dr. Meyers has faced one dismissal after another as cases against another hospital, another hospital's attorney, two outside reviewers, physicians and hospital administrators have been dismissed. This appeal and an appeal against an outside reviewer, John Partridge, M.D., which also is before this Court on a *Writ for Petition for Certiorari,* are the only cases still standing.

REASONS FOR DENYING THE PETITION

I. THE CIRCUITS UNIFORMLY AGREE THAT, AS A THRESHOLD ISSUE, THE COURT ALONE DECIDES WHETHER A PLAINTIFF HAS REBUTTED THE PRESUMPTION OF REASONABLENESS OF PEER REVIEW ACTION.

Without exception, every federal circuit court addressing whether a professional review action

satisfies HCQIA declares that the *court* may decide this threshold issue before trial. *See Singh v. Blue Cross/Blue Shield of Mass., Inc.,* 308 F.3d 25, 36 (1st Cir. 2002); ("[R[easonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment."); *Brader v. Allegheny Gen. Hosp.*, 167 F. 3d 832, 839 (3d Cir. 1999) ("[T]he real issue is the sufficiency of the basis of the [hospital's] actions."); *Gabaldini v. Washington Cty. Hosp.*, 250 F.3d 255, 260 (4th Cir. 2001) (citing *Brader*); *Meyers v. Columbia/HCA Healthcare Care*, 341F.3d 461, 468 (6th Cir. 2003) (plaintiff has burden on summary judgment of proving that review process was unreasonable); *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999) (quoting *Brader*); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)

(quoting House Report's comment that HCQIA "allow[s] court to make a determination that the defendant has or has not met the standards specified in section 11112(a)"); *Brown v. Family Pract. Asoc.*. 101 F.3d 1324, 1334 n.9) (10th Cir. 1996) ("[T]he proper inquiry for the court is whether [the physician] has provided sufficient evidence to permit a jury to find that she has overcome . . . any of the four statutory elements . . . ."); *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1332 (11th Cir. 1994) ("HCQIA immunity is a question of law for the court to decide and may be resolved whenever the record in a particular case becomes sufficiently developed.").

In that regard, every circuit applies the same test devised by the Ninth Circuit in *Austin v. McNamara:* "Might a reasonable jury, viewing the

facts in the best light for [the physician], conclude that he has shown by a preponderance of the evidence that the defendants' actions are outside the scope of 11112(a)?" 979 F.2d at 734 (9th Cir. 1992) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254 (1986)). This uniformity among the circuits flows from congressional intent: "The Committee intends that these provisions [will] allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. The provisions w[ill] allow a court to make a determination that the defendant has or has not met the standards specified in section [11112(a)]." *Id.* (quoting H.R. Rep. 903, 99th Cong., 2d Sess. 12, *reprinted in* 1986 Code Cong. & Admin. News 6394).

For all practical purposes, the purported split among the circuit courts—as claimed by Dr.

Meyers—is much ado about nothing. The only sources of the alleged split are the First Circuit's decision in *Singh v. Blue Cross/Blue Shield* and the Eleventh Circuit's ruling in *Bryan v. James E. Holmes Regional Medical Center*. Both decisions address the roles of the judge and jury in HCQIA cases, and both adopt the test first articulated in *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992): "[M]ight a reasonable jury, viewing the facts in the best light for [the physician], conclude that he has shown . . . that the defendants' actions are outside the scope of 11112(a)?" *Singh*, 308 F.3d at 32; *Bryan*, 33 F.3d at 1333. The only perceived difference is whether a jury may decide the ultimate question: has a defendant met the four requirements for immunity to apply?

In *Singh,* the First Circuit unequivocally rejected the physician's suggestion that the statutory presumption of immunity denies him his Seventh Amendment right to a jury trial. *Singh,* 308 F.3d at 32. The court declared, "Given the objective standards set forth in the statute, reasonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment." *Id.* at 36. The First Circuit then declared that no reasonable jury could find that Blue Cross had failed to satisfy the HCQIA standards, and it affirmed the district court's entry of summary judgment. *Id.* at 48.

Likewise, in *Bryan v. James E. Holmes Medical Center,* the Eleventh Circuit declared that HCQIA immunity "is a question of law for the court to decide and may be resolved whenever the record

in a particular case becomes sufficiently developed." *Bryan*, 33 F.3d at 1332. Examining the record, the court reversed a jury verdict favoring a physician and declared that the district court should have granted the hospital's motion for judgment as a matter of law under Rule 50(b). *Id.* at 1337.

The Eleventh Circuit, however, did not vitiate the jury's function. The court declared that if disputed issues of fact exist about a subsidiary issue, including whether the hospital did not satisfy any of the four requirements for HCQIA immunity to attach, the court may submit that issue to the jury. *Id.* at 1333. The Eleventh Circuit merely observed that the ultimate issue of immunity is a legal question reserved to the court. *Id.*

Citing almost every other Circuit, *including* the Eleventh Circuit in *Bryan*, the First Circuit

noted in *Singh*, "[T]he statutory scheme contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity." *Singh,* 308 F.3d at 33-34. In a single footnote, the First Circuit observed that *Bryan* contains an "internal inconsistency": on one hand, the Eleventh Circuit describes an instance in which a jury may decide whether a hospital has met a requirement for immunity; on the other, the Eleventh Circuit ruled that the court alone decides the ultimate question of immunity. *Id.* at 34 n.7. The First Circuit merely declined to adopt the Eleventh Circuit's declaration that the court alone determines the ultimate question of immunity. *Id.*

Upon closer scrutiny of its ruling, including its describing a jury's involvement in the issue of whether a physician was given adequate notice of

the charges and an opportunity to be heard, the Eleventh Circuit might have realized that it was describing one of the four requirements for immunity. *See* 42 U.S.C. § 11112(a)(3). A jury's determination of that "subsidiary issue of fact" effectively would dictate the ultimate issue of whether the defendant enjoys immunity under HQCIA. The Eleventh Circuit would recognize this "internal inconsistency" and, instead of declaring that the ultimate question of immunity rests with the judge, would note that, for all intents and purposes, a jury's role in deciding a factual issue could dictate whether a defendant enjoys immunity. That acknowledgment would not unite any division between any circuits but merely would clarify the respective roles of the judge and the jury. By no means would clarification of any purported division

alter the outcome in this case because, like many courts before it that faced the same issue, this trial court ruled as a matter of law that Riverside's peer review action was reasonable.

II. THE TRIAL COURT APPLIED THE STATUTORY STANDARD OF OBJECTIVE REASONABLENESS AND NOT ANY "DEFERENTIAL STANDARD."

Dr. Meyers asserts that Riverside urged the trial court to defer to the judgment of the peer reviewers and to ignore his allegations in his myriad amendments. Whatever Riverside encouraged the court to do does not dictate what the court actually did. In any event, Dr. Meyers is *wrong*: Riverside implored the trial court to examine the allegations and to apply HCQIA's presumption of immunity but not to substitute the trial court's personal vision of a reasonable peer action from the perspective of the

actual peer reviewers. *Petition for Writ* (App. J at 33a). This request flowed from directly congressional intent and common law: "Under [HCQIA], the Court's role 'is not to substitute [its] judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges.'" *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318 (11th Cir. 1994), *cert. den.*, 514 U.S. 1019 (1995).

Dr. Meyers contends that the trial court ignored HCQIA's standard of objective reasonableness and, instead, applied a standard of judicial deference. Considering that the trial court granted Dr. Meyers leave to amend his action three times, with each amendment amplifying the facts surrounding Dr. Meyers' suspension, this Court will be hard-pressed to conclude that the trial court

shrugged off Dr. Meyers' assertion that the peer review action must be objectively reasonable. Moreover, the trial court's successive rulings, which mention nothing of judicial deference, clearly rebut Dr. Meyers' argument:

> I find from the exhibits and arguments of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

Petition for Writ (App. F at 16a ¶ 1).

> The Court granted the Plaintiff's oral motion to file a written motion to reconsider the ruling . . . that the Defendants' actions complied with the statutory standards under [HCQIA] and that the Plaintiff had failed to rebut the Defendants' presumption of immunity . . . .

Id. (App. C, 7a ¶ 1). The record clearly demonstrates that the trial court did not give

Riverside a pass but, instead, examined the allegations and the hundreds of exhibits that became a part of the record and concluded that Dr. Meyers had not rebutted the presumption that Riverside's action was reasonable.

Dr. Meyers also misstates the trial court's purported reliance on Virginia common law. Nowhere in the court's letter opinions and orders does the trial judge cite the opinions identified by Dr. Meyers, nor does the court remark that judicial deference carries the day.

In fact, the cases cited by Dr. Meyers relate a physician's seeking injunctive relief for the refusal of a hospital to grant privileges or for a hospital's suspension of privileges—

not to a physician's seeking damages for the suspension or revocation of those privileges. *See Medical Ctr. Hosp. v. Terzis*, 235 Va. 443, 367 S.E.2d 728 (1988) (reversing trial court's injunction against hospital's suspension of doctor's privileges); *Khoury v. Community Mem. Hosp.,* 203 Va. 236, 123 S.E.2d 533 (1962) (declaring that trial court lacks authority to enjoin hospital's refusal to grant privileges). Although these cases do reflect the courts' reluctance to interfere with a hospital's internal affairs, they declare nothing about courts' power to provide financial redress. Consequently, Dr. Meyers misstates that the trial court simply deferred to the judgment of the peer review participants.

III. THE TRIAL COURT APPLIED THE CORRECT STANDARD WHEN AWARDING ATTORNEY'S FEES AND COSTS, AND THAT AWARD IS SUBJECT TO AN ABUSE OF DISCRETION.

HCQIA not only encourages frank peer review through reviewers' immunity from damages but also discourages unreasonable challenges to peer review through the reviewers' recovery of attorney's fees:

> [T]o the extent that a defendant has met the standards set forth under section 1111(a) . . . and the defendant substantially prevails, the court shall . . . award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

42 U.S.C. § 11113; *see Addis v. Holy Cross Health Care Sys. Corp.*, 88 F.3d 482, 485 (7th Cir. 1996)

(noting § 11113's "fee-shifting provision designed to deter plaintiffs from filing meritless lawsuits"). Court consistently review a trial court's award or denial of attorney's fees in HCQIA cases for abuse of discretion. *See, e.g., Johnson v. Nyack Hosp.*, 964 F.2d 116, 123 (2d Cir. 1992); *Muzquiz v. W.A. Foote Mem. Hosp.*, 70 F.3d 422, 431 (6th Cir. 1995); *Addis v. Holy Cross Health Care Sys. Corp.*, 88 F.3d 482, 486-87 (7th Cir. 1996); *Sugarbaker v. SSM Health Care*, 187 F.3d 853, 857 (8th Cir. 1999); *Smith v. Ricks*, 31 F.3d 1478, 1487 (9th Cir. 1994).

In this case the record speaks volumes, with the three amendments to the original action composing merely a small stanza. Before Dr. Meyers even filed the original action, Riverside had offered to re-instate his privileges subject to a proctorship, and within four months after he filed suit Dr.

Meyers had entered into a proctorship agreement. Dr. Meyers was not content: he filed suit against Riverside, another corporate medical provider,[11] and five peer review participants and over the next five years propounded hundreds of requests for admissions, interrogatories and requests for production of documents.

Riverside produced thousands of pages of patient charts and peer review records. Riverside and the individual defendants also answered numerous rounds of discovery. Riverside defended the depositions of all the co-defendants and approximately 25 other participants in the peer review process, including hospital administrators, doctors and nurses. Convinced that Riverside was

---

[11] Dr. Meyers later agreed that the claims against another corporate co-defendant, Urology of Virginia, Inc., should be dismissed with prejudice from the case.

out to get him, Dr. Meyers even deposed the plaintiff in a malpractice action that had not been pursued, the woman who had suffered a heart attack on the operating table. He failed to extract from her any evidence that Riverside had encouraged her to file suit. In fact, that suit named Riverside *as a co-defendant.*

The absurdity did not end with discovery. After the trial court dismissed claims for implied breach of contract and conspiracy and as he faced a *Motion for Summary Judgment* based on a more expansive depiction of the peer review process than he had portrayed, Dr. Meyers sought permission to file a *Third Amended Motion for Judgment.* Over Riverside's strong objection, the court indulged Dr. Meyers again. Ironically, this pleading expanded the court's view of a reasonable peer review process.

Facing another motion to dismiss, Dr. Meyers filed a *Motion for Reconsideration,* which failed to re-examine the law but, instead, raised new allegations of fact and injected more documents into the record. Those documents that Dr. Meyers described but failed to include as exhibits Riverside itself put into the record over Dr. Meyers' objection.

After years of reading pleadings and amendments, the trial court determined properly that the peer review action was reasonable:

> . . . I have reviewed the many briefs filed, the cases cited and the 100 exhibits filed with plaintiff's Motion for Reconsideration.
>
> I have previously found, and again today find, from the pleadings, exhibits, briefs, records of other cases,[12] and after

---

[12] The "records of other cases" refers to the other actions filed by Dr. Meyers, all of which have been dismissed, and to other cases sharing similar legal issues, the factual underpinnings of which were explored to show their similarity with this case.

> reviewing plaintiff's Motion for Reconsideration, his brief supporting the Motion for Reconsideration with the attached 100 exhibits, that the process and standards for professional review of the defendant Hospital under [HCQIA] were reasonable . . . ."

Petition for Writ (App. B, 4a ¶¶ 2,3). Without ruling on whether Dr. Meyers' action was unreasonable, the court noted that the parties would brief or have a hearing on Riverside's previously filed motion for attorney's fees and costs. *Id.* (App. B, 5a ¶ 5).

Not only did the parties brief their positions regarding the reasonableness of Dr. Meyers' action in the filing of and pursuit of litigation, but they also presented oral argument on their respective positions. Having considered the record,[13] the Court awarded Riverside its attorney's fees and costs from

---

[13] Dr. Meyers quotes from the transcript of the hearing beginning at page 86. *See Petition for Writ* (App. D, 11a)

April 10, 2003, through April 20, 2006. That span coincides with the Court's granting Dr. Meyers leave to file a *Second Amended Motion for Judgment* at a hearing on April 9, 2003, and its hearing oral argument on various motions on April 20, 2006, including Riverside's *Motion for Reconsideration of Demurrer,* which hearing led to the court's dismissal of the case.

The record belies Dr. Meyers' positions about the court's findings of the parties' reasonableness in the peer review process and in the litigation. Examining the voluminous record, the court denied Riverside over $120,000 in attorney's fees and costs incurred before the hearing on April 9, 2003, when the court finally stopped giving Dr. Meyers the benefit of the doubt, and after April 20, 2006, when Riverside faced Dr. Meyers' improvidently filed

Motion for Reconsideration. And contrary to Dr. Meyers' assertion, the court made a legal finding that the peer review process was reasonable, *see id.* (App. B, 4a ¶¶ 3-4), and then an independent factual finding that no person involved in the peer review process made any knowingly false statement. *Id.* (App. B, 5a ¶ 1). Because HCQIA immunizes from damages all persons in the peer review process if the action was reasonable, the court was not required to examine the allegations of knowing falsehoods. *See* 42 U.S.C. § 11111(a)(1).

Having done so, however, the court "further [found] no evidence" of any person's knowingly providing false information. *Id.* (App. B, 4a ¶ 4 - 5a ¶ 1). HCQIA excludes immunity to those persons who provide "knowingly false" information—not those who acted recklessly—but only if the process

itself was unreasonable. *See id.* § 11111(a)(1), -(a)(2). Consequently, even a finding of recklessness would not satisfy a requirement of Dr. Meyers' proving "knowing falsehood." Consequently, not only did the trial court properly conclude that the process was reasonable and that the participants are immune but it also entertained Dr. Meyers' assertion that any person knowingly made a false statement even when the first conclusion mooted the second issue.

On one point Dr. Meyers is correct: like any case involving medical peer review, the facts of this case differ from the next. Its factual differences, however, do not create a case of first impression. A case of first impression presents an unanswered legal question. *See California v. Federal Energy Reg. Comm'n*, 495 U.S. 490, 497 (1990). Dr. Meyers

would have this Court declare that his allegations, if true, render the peer review action unreasonable. He misses the mark:

> HCQIA's objective reasonableness standard is a perfectly valid guide for peer review bodies. The "reasonable belief" standard embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence. [Citation omitted.] Courts respect this discretion because "any attempt to catalog every medical practice that would fall into the prohibited category would result in the sort of encyclopedic and unwieldy statute [already] rejected as unnecessary." [Citation omitted.]

Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205, 212-13 (4th Cir. 2002).

Courts consistently have affirmed adverse actions against suspended physicians even if those

physicians actually did not harm anyone or the ultimate determination of whether a physician should have been suspended demonstrates that the precautionary action was unwarranted. *See, e.g., Singh v. Blue Cross/Blue Shield of Mass.*, 308 F. 3d 25, 41 (1st Cir. 2002) (reversal of committee's recommendation does not indicate that initial adverse recommendation was made without reasonable belief that recommendation would further quality heath care."); *Patel v. Midland Mem. Hosp.*, 298 F.3d 333, 339 (5th Cir. 2002) (physician rebutting reports supporting suspension fails to rebut reasonableness of medical executive committee); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 913 (8th Cir. 1999) (physician showing that bases for precautionary suspension were unjustified fails to rebut presumption that participants had

reasonable belief that suspension would further quality health care); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994) (physician's proof that reviewers lacked understanding fails to contradict existence of reasonable belief that participants were furthering health care quality); *Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992) (hearing panel's finding that revocation was unreasonable does not overcome presumption that defendants acted in reasonable belief that suspension was warranted).

Consequently, in a case involving two summary suspensions in 15 months, a failed proctorship, injury to five patients after the first proctorship, and the concurrence of three outside reviewers that some of Dr. Meyers patient charts reveal poor clinical judgment (incident to and after

the initial recommendation)—to say nothing of the protracted litigation leading to dismissal—Dr. Meyers has failed to demonstrate that the trial court abused its discretion when awarding Riverside less than half of the attorney's fees it incurred.

CONCLUSION

Stripped of any purported split over the role of judge and jury in HCQIA cases, this appeal lacks any compelling reason this Court should grant a *Writ*. Devoid of any evidence that the trial court abdicated its responsibility to examine the peer review action objectively, this appeal loses any basis for this Court independently to examine the record below. And considering the trial court's firsthand observations not only of Dr. Meyers' pleadings but also of his course of conduct through several years of litigation, this Court cannot say that Dr. Meyers has

shown any abuse of discretion in awarding Riverside a portion of its attorney's fees and costs. Because the record provides no path leading to a compelling federal question and amounts to no more than Dr. Meyers' challenge to the trial court's findings, this Court should deny his *Petition for Writ of Certiorari.*

Respectfully submitted by

Robert L. Harris, Jr., Esquire
LECLAIRRYAN, A Professional Corporation
Riverfront Plaza, East Tower, 8th Floor
951 East Byrd Street
Post Office Box 2499
Richmond, Virginia 23218-2499
Telephone: (804) 783-2003
Facsimile: (804) 916-7666

Counsel for the Respondents

APPENDIX

* * *

There is no mention of the outflow volume. At 11:20 a.m., the patient had a spontaneous cardiovascular arrest. At that time, 14,950cc of 1.5% glycine had been used, 7700cc had been collected in the suction canisters, and urine output was recorded at 2500cc. Consequently, there was a fluid deficit of approximately 5000cc at the time that the patient experienced a cardiovascular arrest. Prompt cardiopulmonary resuscitation ensued, additional IV Lasix, and hypertonic saline was administered, and to everyone's good fortune, the patient apparently recovered with no permanent neurologic sequelae.

This case is disturbing for a number of reasons. There appears to be inadequate nursing notes to document appropriate fluid management. If the nurse was keeping a running count of fluid volume used for distention as compared to the volume of fluid obtained in the suction canisters, there is no record of this. There is no documentation of regular communication with the surgeon in the nursing notes until 10:50 a.m., a full one and a half hours after the start of the surgical procedure. By then, there already existed a 3000cc deficit.

The physician was either unconcerned or ignored the potential complications associated with intravascular intravasation of fluids during operative hysteroscopy. A lack of clinical electrolyte determination, administering Lasix and, apparently, being informed by the circulating nurse that the fluid deficit was increasing. The physician should have been aware that commonly used liquid distention media (i.e. glycine 1.5%) can result in significant hyponatremia and hypo-osmolality. Review of the medical literature suggests that seizures, permanent brain damage, and death can occur with serum sodium levels of 116mmol/L.

* * *

Under no circumstances should an operative hysteroscopic resection of a uterine fibroid extend beyond an hour and 30 minutes. Ideally, these surgeries should be limited to less than 60 minutes.

* * *

Jay M. Cooper, M.D.

Appendix A-2

Riverside Regional Medical Center
Panel Hearing

IN RE: Paul J. Meyers, M.D.

Day VII

Date: May 23, 2001

DR. SMITH: Back to Ms. Artis, you mentioned earlier that you do take some responsibility for her situation. Would you say that you exhibited impaired intraoperative clinical judgment on her?

THE WITNESS: I think I miscalculated, and I think that -- and I think I made a mistake. I think we all have. Everybody has 10 or 15 minutes in their lives that they'd rather relive.

Page 178, lines 15-2

Appendix B-1

VIRGINIA:

IN THE CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS

BRANDI M. PENNY, Plaintiff,

v. Case No. 31614W-01

PAUL J. MEYERS, M.D.
106 Flag Creek Road
Yorktown, Virginia 23693

and

RIVERSIDE HOSPITAL, INC.
SERVE:
Richard J. Pearce
Registered Agent
606 Denbigh Boulevard
Suite 601
Newport News, Virginia 23608 Defendants.

MOTION FOR JUDGMENT

COMES NOW Plaintiff, BRANDI M. PENNY ("Penny"), by counsel, and for her Motion for Judgment against Defendants PAUL J. MEYERS, M.D. ('Meyers") and RIVERSIDE HOSPITAL, INC. ("Riverside"), states the following:

Parties

1. Penny is a resident of the Commonwealth of Virginia who reasonably relied upon Defendants to perform services on her behalf. Upon reasonable information and belief, Defendants failed to properly perform those services and Penny sustained permanent injuries as a result.
2. Defendant Meyers is believed to be a physician practicing the medical business of obstetrics and gynecology in the City of Newport News, Virginia. Beginning in 1993, and at all material times hereto, Penny and Meyers had a patient-physician relationship, continuously and without interruption through February 2000. At all material times hereto, Meyers was also an employee, principal, or other agent of Defendants Riverside and all of his actions were

performed within the scope of his employment or agency with Riverside.

3. Defendant Riverside is a Virginia corporation, d/b/a Riverside Regional Medical Center ("RRMC"). Riverside maintains its registered office in the City of Newport News. At all material times hereto, Defendant Riverside employed Defendant Meyers to carry out its business, and Defendant Riverside is vicariously responsible for his actions.

4. Defendant Riverside also negligently granted and maintained employment and staff privileges for Defendant Meyers, for which actions it is directly liable to Penny.

Virginia Physicians for Women

September 25, 2000

Thomas T. Thames, II, M.D.
Vice President Medical Affairs
Bon Secours Hampton Roads
150 Kingsley Lane
Norfolk, Virginia 23505

Re: Review of cases of Dr. Paul Meyers
PRELIMINARY FINDINGS AND REPORT

Dear Dr. Thames:

Attached are summaries of my critiques of each of the files you forwarded.

You will note that in none of the cases did I find glaring or consistent deviation from Standard of Care or basic principles of sound practice.

Yet the pattern as a whole raises some serious concerns. In some of the files, the charting is faulty with conflicting information or operative notes long overdue. In other cases, selection of procedural technique and approach is tenuous. And the cluster of adverse events, especially bowel injuries, is far higher than expected even for a surgeon in the learning curve of laparoscopic skills.

What comes through as a strong impression is that of a surgeon pushing the envelop of what can done laparoscopically and accumulating complications in

the process. While some of the injuries occur with Dr. Meyers' non-laparoscopic cases, these seem fewer, more random, and more understandable.

Please feel free to contact me to discuss this review in more detail.

Sincerely,

John R. Partridge, M.D., F.A.C.O.G.

Appendix D-2

Excerpt of Report of Jordan G. Pritzker, M.D.
December 26, 2000

The charts reviewed of the practices of Dr. Meyers reflect significant adverse (and costly) outcomes to the care of a number of the patients in a short period of time (three months). Many of the outcomes may have been averted by a more judicious selection of the surgeries for the patients or less aggressive intervention in the operating room. These outcomes, as documented in the hospital charts, suggest significant concerns in the management of the patients reviewed and for other potential surgical patients of the doctor reviewed. Earlier intra-operative consultation may have averted some (or allowed for a 'shared' responsibility) of the outcomes of the patients. The rationalization for the procedures performed and the ensuing outcomes may be better substantiated by the specific patient office charts of Dr. Meyers.

The threshold for which to restrict or suspend a doctor's practice based on the outcomes of patients of certain procedures is subjective, particularly when the career of a colleague is "on the line." The outcomes of the patients herein reviewed suggest that, in the least, possible pre-operative review and surgical supervision of this doctor may be of benefit to the quality of care of the patients in the community.

Excerpt from:

Investigative Committee Report
Paul Meyers, M.D.
July 15, 2000
Page 3.

Dr. Meyers practice patterns will not change therefore, the frequency of complications will not change.

The committee based its finding on the fact that Dr. Meyers had recently completed a 3 month period of proctorship following a similar peer review investigation in December 1999. It was the conclusion of the 1999 review that he demonstrated significantly impaired clinical judgment in the preoperative, intra-operative and postoperative management of four patients under his care at the time.

Following the resumption of his laparoscopic privileges in October 1999, he was noted again to have experienced an increased number of complications in a short period of time.

The committee currently finds that there remains a similar pattern of behavior as note during the 1999 Investigation. His clinical behavior of aggressive case selection and intra-operative decision-making

leads him to proceed when others may take a more conservative approach. This has led to several intra-operative misadventures and potentially avoidable complications.

Because of a pattern of this behavior, several prior reviews before the medical executive committee, and the present action, the committee believes this behavior will not change and will ultimately place patients at an unacceptably high risk.

Riverside Regional Medical Center

June 8, 2001

Paul Meyers MD
106 Flag Creek Road
Yorktown, VA 23693

Dear Dr. Meyers:

I am informing you that the Medical Executive Committee met on Wednesday, June 6, 2001 to review the report and recommendations of the hearing panel that was selected pursuant to the adverse peer review recommendation of the MEC on July 25, 2000. I am aware that Mr. Tom Carpenter, the hearing officer forwarded a copy of their report to you via certified mail on Tuesday, June 5, 2001.

The Medical Executive Committee has voted to reverse their original recommendation for revocation of staff appointment and all clinical privileges. They also voted to accept the hearing panel's recommendations with the following modifications as listed below:

1. Request that the Departmental Chair for Obstetrics/Gynecology at Riverside Regional Medical Center appoint a three (3) person task force to develop the criteria for proctorship. This would include the departmental chair, a member from the department appointed by him and a member from the department recommended by you. The task force will work in conjunction with

the Director of Surgical Services and the Vice President of Medical Affairs.

The Medical Executive Committee cannot accept the panel's recommendation that the condition for a remedial course and proctorship be made concurrent wit that of Mary Immaculate Hospital. The granting of privileges is institution specific. To the extent that the timing of the two organizations" processes happen to coincide, that would be fortuitous, but Riverside will go forward with the process described above notwithstanding any process at Mary Immaculate. Please provide information regarding any laparoscopic course(s) that you have undertaken.

The recommendations for the criteria and the scope of the proctorship shall be submitted to the Medical Executive Committee for their review and adoption.

2. The Hearing panel recommended that all operative reports be completed in the time frame established by the Department of Obstetrics/Gynecology and the Department of Medical Records. The requirement and sanctions for medical record compliance is the sole responsibility of the Medical Records committee and the Medical Executive Committee.

3. The Medical Executive Committee will require that you agree to not tape record any conversations or meetings with members of the medical and hospital staff without their consent.

This recommendation with the stipulated modifications will be forwarded immediately to the Board for final action at its meeting on June 27, 2001 because this recommendation is not adverse to you.

Pursuant to the Medical Staff Bylaws, Article XI, Section 1, you have within fourteen (14) days of your receipt of this letter to request an appellate review, if you believe this recommendation is adverse to you. The final Board action would then occur following the appeal process. The request shall be in writing, and shall be delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within fourteen (14) days as provided, you shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective."

Until this recommendation has been reviewed and adopted by the Board of Directors, your voluntary agreement to not exercise your clinical privileges remains in place.

Sincerely,

William B. Downey
Executive Vice President/Administrator

CC: Rudolph Freeman Jr., MD
Vice President of Medical Affairs

AFFIDAVIT OF PAUL J. MEYERS, M.D.
Dated December 19, 2007

11. I completed my proctorship of vaginal cases on or about July 2006. I have been proctored for 6 laparoscopic cases. I have not had open abdominal cases to proctor because I do almost all of my gynecological procedures that are suitable to a vaginal or laparoscopic approach and rarely do gynecological procedures through an abdominal incision. I consider that it would be unethical for me to inflict on patients an abdominal incision just so that I could complete proctorship of my abdominal cases. My proficiency or competence to perform gynecological operations abdominally was never questioned or criticized, and none of the actions taken on my privileges were based on abdominal gynecological operations (or vaginal operations for that matter).